## Virginia Electric and Power Company North Anna Power Station 1022 Haley Drive Mineral, Virginia 23117

#### December 6, 2013

Attention: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, DO 20555, 2004

Washington, DC 20555-0001

Serial No.: 13-581 NAPS: JHL

Docket No.: 50-338 License No.: NPF-4

#### Dear Sirs:

Pursuant to 10CFR50.73, Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Power Station Unit 1.

Report No. 50-338/2013-002-00

This report has been reviewed by the Facility Safety Review Committee and will be forwarded to the Management Safety Review Committee for its review.

Sincerely,

Gerald T. Bischof Site Vice President

North Anna Power Station

#### Enclosure

Commitments contained in this letter: None

cc: United States Nuclear Regulatory Commission

Region II

Marquis One Tower

245 Peachtree Center Ave., NE, Suite 1200

Atlanta, Georgia 30303-1257

NRC Senior Resident Inspector North Anna Power Station

> IE22 NRR

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION (10-2010)  APPROVED BY OMB NO. 3150-0104 EXPIRES: 10															
(10-2010)  LICENSEE EVENT REPORT (LER)  (See reverse for required number of digits/characters for each block)									Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor and a person is not required to respond to the						
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FACILITY NAME  Gerald T. Bischof, Site Vice President  (540) 894-2101								irea Code)							
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D	EA	XF	MR		Y										
14. SUPPLEMENTAL REPORT EXPECTED							15. EXPECTED MONTH DAY								
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)															
On October 11, 2013, at 1319 hours with Unit 1 operating at 48 percent power (Mode 1), an															
automatic turbine trip and subsequent reactor trip occurred due to a lockout relay actuation for															
the 1C Station Service Transformer (1-EP-SST-1C). The lockout occurred simultaneously with the start of the 1C Condensate Pump (1-CN-P-1C). The direct cause of the 1-EP-SST-1C															
lockout is that current transformer terminal block shorting screws were left installed inside the 1-															
EP-BKR-15C2 breaker cubicle. The root cause of the event was less than adequate written															
instructions for documenting the installation and removal of the terminal block shorting screws.															
All safety system responded as expected. The Auxiliary Feedwater Pumps actuated as															
designed following the reactor trip and provided makeup flow to the Steam Generators. 1-EP-															
SST-1C was inspected and no signs of damage or abnormal conditions were observed. At 1507 hours, a 4 hour report was made to the NRC in accordance with 10CFR50.72(b)(2)(iv)(B) for a															
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Reactor Protection System (RPS) actuation and a 8 hour report in accordance with

10CFR50.72(b)(3)(iv)(A) for a Auxiliary Feedwater system actuation. The event is reportable pursuant to 10CFR50.73(a)(2)(iv)(A) for a condition that resulted in the automatic actuation of the RPS and AFW Systems. The health and safety of the public were not affected by the event.

NRC FORM 366 (10-2010)

NRC FORM 366A (10-2010)

## LICENSEE EVENT REPORT (LER)

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		YEAR	SEQUENTIAL NUMBER	REV NO.				
NORTH ANNA POWER STATION UNIT 1	05000 - 338	2013	002 <b></b>	00	2 OF 4			

NARRATIVE

#### 1.0 DESCRIPTION OF THE EVENT

On October 11, 2013, at 1319 hours with Unit 1 operating at 48 percent power (Mode 1) following a refueling outage, an automatic turbine trip and subsequent reactor trip occurred due to a lockout relay (EIIS Component-86) actuation for the 1C Station Service Transformer (1-EP-SST-1C) (EIIS System-EA, Component-XFMR). The lockout occurred simultaneously with the start of the 1C Condensate Pump (1-CN-P-1C) (EIIS System-SD, Component P) during unit power ascension. When 1-CN-P-1C was started, the increase in starting amps caused a current imbalance in the 1-EP-SST-1C differential circuit which exceeded the protective relay's (EIIS Component-87) trip point. Once this trip point was exceeded the differential protective relay initiated a trip signal to its associated Station Service Transformer lockout relay. This current imbalance was falsely created due to current transformer (EIIS Component-XCT) shorting screws being left installed in the 1-EP-BKR-15C2 (EIIS Component-BKR) cubicle, which disabled half of the needed current inputs into the differential protective relay.

All safety systems responded as expected during the event. All control rods (EIIS System-AA, Component-ROD) inserted into the core at the time of the trip. Due to low decay heat loads, the Main Steam Trip Valves (EIIS System-SB, Component-V) were closed as the Reactor Coolant System (RCS) (EIIS System-AB) average temperature decreased, as directed by the reactor trip response procedure and decay heat was removed using the atmospheric steam dumps. Decay heat control was subsequently transferred to the main condenser steam dump system (EIIS Component-COND). The auxiliary feedwater (AFW) pumps (EIIS System-BA, Component-P) received an automatic start signal as designed following the reactor trip and provided makeup flow to the steam generators (SG) (EIIS Component-SG). The SG levels were subsequently restored to normal operating level and the AFW pumps were secured and returned to automatic.

## 2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS

No significant safety consequences resulted from this event since the Reactor Protection System (RPS) (EIIS System-JC) and the Engineered Safety Feature (ESF) System (EIIS System-JE) equipment responded as designed. No visual signs of damage to equipment occurred during the event. No fault pressure relay or mechanical relief device operated which would have been indicative of an internal fault in 1-EP-SST-1C. The event posed no significant safety implications and the health and safety of the public were not affected by the event.

At 1507 hours, a 4 hour report was made to the NRC in accordance with 10CFR50.72(b)(2)(iv)(B) for a Reactor Protection System (RPS) actuation and a 8 hour report in accordance with 10CFR50.72(b)(3)(iv)(A) for a Auxiliary Feedwater System actuation. The event is reportable pursuant to 10CFR50.73(a)(2)(iv)(A) for a condition that resulted in the automatic actuation of the RPS and AFW Systems.

#### NRC FORM 366A

(10-2010)

# CONTINUATION SHEET

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NARRATIVE

#### 3.0 CAUSE

The direct cause was the presence of six shorting screws that were not removed from 1-EP-BKR-15C2 cubicle following design change replacement of the under voltage relay.

The root cause of the event was less than adequate written instructions for documenting the installation and removal of shorting screws, which resulted in a loss of configuration control.

The contributing cause of the event was less than adequate training, for maintenance type activities, is provided to Control Operations personnel when compared to station maintenance training programs.

#### 4.0 IMMEDIATE CORRECTIVE ACTION(S)

The Control Room crew responded to the reactor trip in accordance with emergency procedure 1-E-0, Reactor Trip or Safety Injection. The post trip response progressed as expected and the Control Room crew transitioned to 1-ES-0.1, Reactor Trip Response. All safety systems responded as designed.

## 5.0 ADDITIONAL CORRECTIVE ACTIONS

Visual inspections were performed of all current transformer (CT) blocks for the Generator, Main Transformers and Station Service Transformers. No additional shorting screws were inappropriately installed.

Visual inspection of the 1-EP-SST-1C was performed. No visual signs of damage or abnormal conditions were observed. No fault pressure relay or mechanical relief device had operated which would have been indicative of an internal fault in the transformer.

Oil samples taken on 1-EP-SST-1C and analyzed by the Dominion Oil Analysis Lab confirmed no abnormal results.

Current traces from the Digital Fault Recorder were analyzed to determine if an actual fault had occurred. Normal load current for the equipment being powered from the 1-EP-SST-1C prior to the event was observed. Normal starting current for manual start of 1-CN-P-1C was observed just prior to the lockout relay actuation (approximately 8 cycles).

The differential relays for 1-EP-SST-1C were tested and determined to be operable.

Corrective and design change work orders were reviewed to ensure work order job steps contain adequate means for tracking configuration control changes, corrected work orders.

## NRC FORM 366A (10-2010)

#### U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

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#### 6.0 ACTIONS TO PREVENT RECURRENCE

Corrective actions are being tracked under root cause evaluation RCE001110. Corrective actions include: 1) development of a Job Familiarization Guide for planner qualifications, 2) implementation the Job Familiarization Guide for planner qualifications, and 3) revising WM-AA-101 "Work Order Planning" to include notes and/or procedure steps to direct use of configuration control tracking documentation when approved procedures are not available to control configuration.

#### 7.0 SIMILAR EVENTS

None

#### 8.0 ADDITIONAL INFORMATION

Unit 2 was operating in Mode 1, 100 percent power on October 11, 2013 and was not affected by this event.

Description: Station Service Transformer (1-EP-SST-1C)

Manufacturer: HYOSUNG Corporation (HICO)